UNIVERSITY OF MALAWI MEDICAL SCHEME (UNIMED)
STAFF CARD REPLACEMENT REQUEST FORM

I request for a replacement of my UNIMED membership card which was:

1) LOST: ☐

2) DAMAGED: ☐

3) OTHER (Please explain): _____
_____
_____

MEMBERSHIP DETAILS

SURNAME: _____
FIRST NAME(S): _____
DATE OF BIRTH: _____
DATE JOINED: _____
LOCATION: _____
COVER: _____
MEMBERSHIP NUMBER: _____

PAYMENT DETAILS

Please Deposit a card replacement fee of **MK10,000.00** to the following account and fax the deposit slip together with this form to UNIMED on **(+265) 01 524 666**

Account name: **UNIVERSITY OF MALAWI MEDICAL SCHEME**
Account type: **CURRENT**
Bank: **NATIONAL BANK OF MALAWI**
Branch: **ZOMBA**
Account number: **273279**

MEMBER'S SIGNATURE: _____DATE:_____

FOR UNIMED USE ONLY:

Approved: _____Signature_____ Date Stamp